Cancer Detection Programs: Every Woman Counts
RECIPIENT ELIGIBILITY FORM

First page to be completed by recipient

Recipient ID | | | **9** | **A** | | | | | | | | | |

1. Last Name

2. First Name

3. Middle Initial

4. Mother's Maiden Name

5. Date of birth (Month--MM) (Day--DD) (Year--YYYY)

6. Address

7. City

8. State

9. ZIP Code

10. Telephone

11. Are you Hispanic or Latino?
☐ Yes
☐ No

12. Select all that apply to you
☐ American Indian or Alaska Native
☐ Asian → 13. (Select one if Asian)
☐ Black or African American
☐ Pacific Islander → 14. (Select one if Pacific Islander)
☐ White
☐ Unknown

13. (Select one if Asian)
☐ Asian Indian
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Laotian
☐ Vietnamese
☐ Other Asian

14. (Select one if Pacific Islander)
☐ Guamanian
☐ Hawaiian
☐ Samoan
☐ Other Pacific Islander

15. Total number of family members living together (applicant, spouse, children aged 20 and younger):

16. Total gross monthly income of family members:

17. I have no health insurance: ☐ None

I have this kind of health insurance:
☐ Medi-Cal
☐ Military
☐ Private insurance
☐ Medicare Part B
☐ Family PACT
☐ Other _____

I certify that the above information is correct and complete:

_____ _____
Recipient signature Date Signed

PROVIDER USE ONLY Eligibility Checklist

Supporting documentation on file establishes that recipient:

18. ☐ Meets program's age criteria for breast and cervical cancer screening and diagnostic programs.
[≥ 40 years of age for Breast Services or ≥ 25 years of age for Cervical Services]
19. ☐ Meets program's income and insurance criteria for breast and cervical cancer screening and diagnostic programs.
[≤ 200% Federal Poverty Level; Payor of Last Resort: Unmet Share Of Cost, Unmet deductible, Exhausted Family PACT, No Medicare Part B]
20. ☐ Recipient referred for Breast and Cervical Cancer Treatment Program (Optional).
21. ☐ Signed program's consent form.

I have determined that this woman is eligible for CDP services*.

_____ _____
Primary Care Provider Staff Certifying Signature Date Certified

**Eligibility determination policies and information are located in the Cancer Detection Programs' Section of the Medi-Cal Manual.*

Complete all fields. Place original in patient chart.